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ABSTRACT

Few sex education materials especially designed for the deaf population are available, and modification of existing materials and media is necessary. The average deaf person cannot easily gain information from books, magazines, or newspapers, for the majority of deaf students read at a level below others of comparable ages. This communication and learning handicap is exacerbated by the fact that the majority of these students have parents with normal hearing. Since sign language is the preferred mode of communication among most of the deaf, lack of knowledge in the use of signs on the part of their parents creates an understanding gap which makes it difficult for parents to deal with the psychosocial-sexual concerns of their children. Currently, there is no parent education program existing for parents of deaf children. Sex education for the deaf requires highly visual materials supported with simple language. Pictures, films, photographs, role playing, and experiential situations are important tools in making concepts about sexuality understood. The physical education department at Gallaudet College (District of Columbia) now offers most incoming students a required course in health with a lengthy section on sex education. (JD)

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THE STATUS OF HEALTH EDUCATION AND SEX EDUCATION PROGRAMS FOR THE DEAF: WHAT IMPLICATIONS DOES THIS HAVE FOR HEALTH EDUCATORS?

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SP 021 967

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Current literature reveals very little data on specific health education needs of deaf children and their parents. This can be attributed to the fact that the deaf population is rather small and health educators have not been attracted to work with this population.

To date no published health education curricula for deaf children or their parents have been located. Very few of the residential schools for the deaf offer an in depth health or sex education curricula.

Recently completed research indicates that 77% of the state residential schools for the deaf already provide some type of sex education instruction. Yet, the quality of instruction that is provided in these residential schools is, at the least, questionable since the classroom teacher was the sex education instructor in residential schools 70% of the instances where sex education was provided. Many of these teachers coming from teacher training programs of the deaf never had a specific course in sex education (Fitz-gerald and Fitz-gerald, 1976).

This lack of a quality health or sex education program can be attributed to what is called "prioritizing." Many educators see the value of health and sex education courses, but, at this time, there are more pressing priorities. These priorities include language and speech development.

Current statistics indicate that 91.7% of American deaf children are born to normal hearing parents. These parents, as a rule, have little awareness of understanding of deafness since few

of them have had any previous contact with a deaf person (Schein and Delk, 1974). Most deaf Americans communicate through sign language. Sign language is the preferred mode of communication among most of the deaf (Kannapell, 1974). This lack of knowledge in the use of signs on the part of their parents can cause tremendous communication barriers, since most hearing parents communicate orally (through speech) expecting the deaf to lip read. Research shows that the very best lipreaders understand only one-fourth of what is said (Vernon, 1972). This communication gap can lead to both parent and deaf child feeling isolated from one another. Many parents of deaf children often feel guilty, angry, and frustrated, sometimes taking it out on the child (Vernon, 1971). Hearing parents often exhaust their energies coping with their own frustrations, thus having little strength to delve into the psychosocial-sexual concerns of their children. One survey of the parents of students attending a leading West Coast school for the deaf indicated that two-thirds were divorced (Vernon, 1971).

Good child sex education evolves from good parent education. Small wonder, perhaps, that deaf persons marry in smaller proportions than hearing persons, and that their marriages prove less stable (Schein and Delk, 1974).

Currently, there is no parent education program existing for parent's of deaf children. This is an area under current investigation by Dr. Updegraff in a special grant from the U.S. Department of Health and Human Services, entitled, "A Comprehensive Health Education Program for the Parents of Deaf Children."

Steve Grossman (1972) conducted one of the few studies that has

attempted to compare sexual knowledge, attitudes, and behavior of American deaf and normal hearing college students. His findings indicated that the deaf students had less sexual knowledge, were generally more accepting of sexual myths and engaged in more sexual activity than their hearing peers. It is the author's opinion that direct experiences constitute the primary means for the deaf person to learn about sexuality. Sex information in Mr. Grossman's study indicated a significant source for sex information was gotten from the peer's of the deaf group.

Based upon current data in America, it appears that the degree of misinformation and the belief in sexual myths are greater among the deaf than among their hearing peers.

Sex Education for the deaf requires highly visual materials supported with simple language. Abstracts concepts like reproduction, parenting, and relationships becomes secondary when the deaf adolescent has to struggle with the basic labeling of one's body parts. Pictures, films, photographs, role playing, and experiential situations are important tools in making concepts about sexuality understood.

Contrary to what most people believe, the average deaf person cannot easily gain important information from such sources as books, magazines, or newspapers. Although their IQs do not vary appreciably from those of their hearing peers, almost half the deaf students age 20 or below read at less than a mid-fourth grade level; and only 10% of the hearing impaired 18 year olds nationally can read at or above the eighth grade level (Trybus and Karchmer, 1977).

The deaf child, because of the nature of the impairment, is denied

the verbal repetition that his hearing counterpart receives. For the deaf child, the integration of just one word into the vocabulary requires that someone point out, show, demonstrate again and again what is being taught.

It becomes more apparent that if the deaf student is to learn from reading, they must have materials written especially for them. It is no small wonder that the deaf student encounters a communication and learning handicap marked by social isolation, underemployment, undereducation and underinvolvement in the mainstream of society. (Switzer and Williams, 1967).

Few sex education materials especially designed for the deaf population are available. (Note: This writer has written two workbooks that have been successfully used at Gallaudet College in the areas of Sex Education and Drug Education). Modification of existing materials and media becomes necessary. No matter how relevant the subject may be, if the deaf youth has to struggle with comprehension, interest will be lost.

Even though sex education for the deaf is behind the times, the picture is not totally bleak. In recent years, movements have developed within the deaf community expressing "deaf pride" and "deaf power" as deaf people have taken a greater initiative than ever before in directing their own affairs and shaping their own destiny. This was recently demonstrated by a proposal of the National Association of the Deaf (NAD) for a grant from the Bureau of Education of the Handicapped to be used for the development of materials and media on sex signs for parents and professionals.

The deaf, like other handicapped persons, are demanding that

their rights to sexual awareness, understanding and fulfillment no longer be denied.

Currently, the Physical Education Department at Gallaudet College offers most incoming students a required course in health with a lengthy section on sex education. Gallaudet College, in 1980, came out with a self-evaluation report that gives substance to the need of this college health course. The report stated,

> "We know our general mission is to improve the quality of life for deaf people. Education is the primary mode by which people enter the field of work, enjoy life, and become part of their society. . . . . The acquisition of health knowledge and principles should be required of college students. This aspect of one's life is essential to the well rounded, well educated citizen. An educational program which involves one in becoming a better citizen and more knowledgeable in the art of living is essential to the welfare of man. The area of health is essential in contributing to the art of living more effectively within the limits of one's individual capacities."

It becomes apparent from this paper and the author's work with deaf students that health professionals in the years to come will be needed to work with this special population, as administrators awaken to this need. We as professionals must be ready for this future role.

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